or uniformly modifying coverage as described in paragraph (e) of this section, the issuer must provide to each plan sponsor written notice of the renewal at least 60 calendar days before the date of the coverage will be renewed in a form and manner specified by the Secretary.

(g) *Construction.* (1) Nothing in this section should be construed to require an issuer to renew or continue in force coverage for which continued eligibility would otherwise be prohibited under applicable Federal law.

(2) Medicare eligibility or entitlement is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market.

(h) *Application to coverage offered only through associations.* In the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, the reference to ''plan sponsor'' is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer.

(i) *Applicability date.* The provisions of this section apply for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

(j) *Grandfathered health plans.* This section does not apply to grandfathered health plans in accordance with §147.140.

[78 FR 13437, Feb. 27, 2013, as amended at 78 FR 65092, Oct. 30, 2013; 79 FR 30339, May 27, 2014; 79 FR 42985, July 24, 2014]

EFFECTIVE DATE NOTE: At 79 FR 53004, Sept. 5, 2014, §147.106 was amended by revising paragraph (b)(5), effective Oct. 6, 2014. For the convenience of the user, the revised text is set forth as follows:

§147.106 Guaranteed renewability of coverage.

* * * * *

(b) * * *

(5) *Enrollees' movement outside service area.* For network plans, there is no longer any enrollee under the plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business); and in the case of the small group market, the issuer applies the same criteria it would apply in denying enrollment in the plan under §147.104(c)(1)(i); provided the issuer provides notice in accordance with the requirements of paragraph (c)(1) of this section.

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§147.108 Prohibition of preexisting condition exclusions.

(a) *No preexisting condition exclusions*—(1) *In general.* A group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion (as defined in §144.103).

(2) *Examples.* The rules of this paragraph (a) are illustrated by the following examples (for additional examples illustrating the definition of a preexisting condition exclusion, *see* §146.111(a)(1)(ii)):

Example 1. (i) *Facts.* A group health plan provides benefits solely through an insurance policy offered by Issuer *P*. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer *N*. *N*'s policy excludes benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy.

Example 2. (i) *Facts.* Individual *C* applies for individual health 2insurance coverage with Issuer *M*. *M* denies *C*'s application for coverage because a pre-enrollment physical revealed that *C* has type 2 diabetes.

(ii) *Conclusion.* In this *Example 2*, *M*'s denial of *C*'s application for coverage is a preexisting condition exclusion because a denial of an application for coverage based on the fact that a condition was present before the date of denial is an exclusion of benefits based on a preexisting condition.

(b) *Applicability*—(1) *General applicability date.* Except as provided in paragraph (b)(2) of this section, the rules of this section apply for plan years beginning on or after January 1, 2014; in the case of individual health insurance coverage, for policy years beginning, or applications denied, on or after January 1, 2014.

(2) *Early applicability date for children.* The rules of this section apply with respect to enrollees, including applicants for enrollment, who are under 19 years of age for plan years beginning on or after September 23, 2010; in the case of individual health insurance coverage, for policy years beginning, or applications denied, on or after September 23, 2010.

(3) *Applicability to grandfathered health plans. See* §147.140 of this part for determining the application of this section to grandfathered health plans (providing that a grandfathered health plan that is a group health plan or group health insurance coverage must comply with the prohibition against preexisting condition exclusions; however, a grandfathered health plan that is individual health insurance coverage is not required to comply with PHS Act section 2704).

(4) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *F* commences employment and enrolls *F* and *F*'s 16-year-old child in the group health plan maintained by *F*'s employer, with a first day of coverage of October 15, 2010. *F*'s child had a significant break in coverage because of a lapse of more than 63 days without creditable coverage immediately prior to enrolling in the plan. *F*'s child was treated for asthma within the six-month period prior to the enrollment date and the plan imposes a 12-month preexisting condition exclusion for coverage of asthma. The next plan year begins on January 1, 2011.

(ii) *Conclusion.* In this *Example 1*, the plan year beginning January 1, 2011, is the first plan year of the group health plan beginning on or after September 23, 2010. Thus, beginning on January 1, 2011, because the child is under 19 years of age, the plan cannot impose a preexisting condition exclusion with respect to the child's asthma regardless of the fact that the preexisting condition exclusion was imposed by the plan before the applicability date of this provision.

Example 2. (i) *Facts.* Individual *G* applies for a policy of family coverage in the individual market for *G*, *G*'s spouse, and *G*'s 13-year-old child. The issuer denies the application for coverage on March 1, 2011 because *G*'s 13-year-old child has autism.

(ii) *Conclusion.* In this *Example 2*, the issuer's denial of *G*'s application for a policy of family coverage in the individual market is a preexisting condition exclusion because the denial was based on the child's autism, which was present before the date of denial of coverage. Because the child is under 19 years of age and the March 1, 2011, denial of coverage is after the applicability date of this section, the issuer is prohibited from imposing a preexisting condition exclusion with respect to *G*'s 13-year-old child.

[75 FR 37235, June 28, 2010]

§147.110 Prohibiting discrimination against participants, beneficiaries, and individuals based on a health factor.

(a) *In general.* A group health plan and a health insurance issuer offering group or individual health insurance coverage must comply with all the requirements under 45 CFR 146.121 applicable to a group health plan and a health insurance issuer offering group health insurance coverage. Accordingly, with respect to an issuer offering health insurance coverage in the individual market, the issuer is subject to the requirements of §146.121 to the same extent as an issuer offering group health insurance coverage, except the exception contained in §146.121(f) (concerning nondiscriminatory wellness programs) does not apply.

(b) *Applicability date.* This section is applicable to group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014. See §147.140, which provides that the rules of this section do not apply to grandfathered health plans that are individual health insurance coverage.

[78 FR 33192, June 3, 2013]

§147.116 Prohibition on waiting periods that exceed 90 days.

(a) *General rule.* A group health plan, and a health insurance issuer offering group health insurance coverage, must not apply any waiting period that exceeds 90 days, in accordance with the rules of this section. If, under the terms of a plan, an individual can elect coverage that would begin on a date that is not later than the end of the 90-day waiting period, this paragraph (a) is considered satisfied. Accordingly, in that case, a plan or issuer will not be considered to have violated this paragraph (a) solely because individuals